SB 553 Nursing Facilities Subgroup Working Document – March 16, 2017

Credentialing

- Licensed Nursing Facilities should have deemed status. All licensed nursing facilities should be authorized providers.
  - State License
  - Medicare Certificate
  - Liability Insurance proof
  - Copy of most recent state survey
- Credentialing and Administrative processes should be consistent among MCOs as determined by DHHS.

Eligibility and Enrollment

- DHHS should maintain eligibility determination.
- Redetermination: Once enrolled in an MCO, there should be a 30 day grace period to try to prevent residents being dropped from service enrollment and having to be re-enrolled. Request MCO's honor full month's coverage if delay in the re-determination process. The goal would be to try to prevent a fee for service billing situation.
- If a client chooses to switch from one MCO to another, MCO to keep client through last day of a month then have new MCO pick up the first day of the next month to prevent administrative burden & delays in payment. Mid-month changes require bills to: MCO #1, then FFS, then MCO #2 within just a few days of one another.
- Nursing home providers should be held harmless if a redetermination/eligibility is retroactively denied (i.e. 90 days).

Transitions (includes discharges, transfers, and MCO-MCO transitions)

- There should be a Presumed Medical Eligibility for Nursing Home admissions from Hospitals. (Assuming financial eligibility requirements are met).
- DHHS should request waiver of the Pre-Admission Screening and Resident Review (PASRR) requirement. This program has not proved instrumental in improving or affecting care for those with Mental Illness and Developmental Disabilities. It becomes an impediment for the timely admission into a nursing facility.
- MCO's must assist and assure smooth transitions to include but not be limited to:
  - Medications (including narcotics), oxygen, equipment and services through all setting changes. There should be no delays due to p/a's through transitions.
- Request MCO support for home visits to include necessary equipment:
  - By offering short term equipment support, complex discharge planning can be assured with savings included to avoid unnecessary re-admissions or ED visits.
- Request MCO support for home trials for Pediatric patients without the financial complication of 2 different service levels (set up a feasible system to avoid double dipping).
- MCOs should work with a facility to bridge between the long term care facility and the home situation in the effort to provide a smooth discharge to home plan,
- MCO's offer /cover 30 day pre-transition support by the case manager who will follow in the community.
- Care plans must be preserved for 90 days during any transition.

Utilization Management

- Continued stay criteria should be standardized among MCOs.
- Billing codes, forms and procedures should be standardized for all MCOs.
- There should be consistent billing documents/standards between MCOs (i.e. like Medicare has the UB-04).
- Any changes in MCO Administrative Rules must be noticed at least 30 days in advance. DHHS should provide a review process where providers can contest unfavorable changes. Facilities should not be denied services required by CMS regulation/guidelines.
- MCO billing systems should be tested in pilot studies or in parallel before a transition is made for all providers. Providers should have alternative billing portals/systems.
- There should be a notification and appeal process prior to any recoupment or take back. The provider may appeal a UM decision requesting consideration by the UM Committee within 30 days from the date of notification. The MCO and provider will work together to designate members of a UM Committee. No member of the UM Committee shall have been involved in the initial determination. If either party is dissatisfied with the result of the decision of the UM Committee, it may request arbitration.
- The Provider agrees to participate in and cooperate with the UM Program and QA Program (UM/QA Program) utilized by the MCO, subject to the Provider's right to appeal any adverse decisions on behalf of itself or as an authorized agent on behalf of the member.

Covered Services

- Covered Services means those healthcare services, equipment, and supplies that are required by federal and state law to be covered under a Member's Benefit Program. The Provider shall be entitled to provide all Covered Services for which it is licensed and required to provide under applicable laws and CMS regulations.
- Consistent among MCOs.
- There should be a respite benefit (for up to 35 days/year).
- For services that are not included in the per diem (e.g. specialty beds), the facility will be allowed to bill the MCO for these services if there is no DME provider in the state that is licensed by DHHS or the member's MCO.
- Make rate adjustments (or supplemental payments) available for additional short term funding to cover infrequent expenses, such as extractions, extensive therapies, staff required to stay overnight for CPAP/BIPAP evaluations, hearing aids, dentures, accommodations for overnight family members to prepare for a transition.
    - It is understood that preventive care and certain procedures (such as extractions) are not currently covered services; however preventive work, dentures, extractions are required for overall recipient health benefits. Savings are realized when proper dentition is able to be supported such that client can eat a regular diet - any alterations in diet costs the providers time and money and the recipients face issues with dignity and maintaining base health levels.
    - 80%+ of residents have memory loss or diagnosis that will impair memory at some point; it is inevitable and not the fault of the provider that residents will misplace, mistreat or otherwise render their hearing aids and/or dentures inoperable. The value in replacing

these (if not otherwise covered) includes the ability to eat normal textures, hear and participate in daily activities. It is less efficient if residents can't hear simply due to their lost/broken appliances that was not through fault of the facility rather a resident action. Care is more efficient when residents are best able to hear and eat normal textures.

- Supplemental payments (with prior authorization) should be made for intensive PT, OT, and Speech for Medicaid only recipients. We are mandated to provide necessary therapy, but there is inadequate reimbursement to offer more intense therapy to a Medicaid only client. CMS regulations require nursing facilities to maintain the highest practicable level of mobility.
- CPAP/BIPAP; work up is costly process. Request one time payments for staff coverage such as is required by us for outpatient tests, appointments or procedures including staff to stay overnight for sleep studies be made available
  - Hospitals/clinics expect providers to send an LNA to appointments. Often this takes up a partial day, and to meet care needs of remaining residents, providers bear the burden of this additional cost. In addition, if a sleep study is ordered an LNA must accompany the resident for the duration of the study.
  - When an appliance such as a "PAP" machine is ordered, Medicare will pay the rental fee when the sleep study was completed. The value of sending an LNA knowledgeable of the resident is that necessary and correct care is supported and the LNA returns with additional communication from the testing or procedure or appointment.
- Request continuation of enhanced alternative rate structure for residents with significant behavioral needs as they are more difficult to manage and current CMI valuing system is punitive to providers who work with behavioral residents.
- **Nursing Facility-Atypical Covered Services for non-behavioral long term care** are described in He-E 802.09 (a). Additionally:
  - Specialty Equipment. For services that are not included in the per diem (i.e. specialty beds) that are medically ordered, the facility will be allowed to bill the MCO for these services if there is no DME provider in the state that is licensed by DHHS or the member's MCO.
  - MCO's should contract with hospitals to cover periods of time a covered individual may be in the hospital while waiting long term placement.
- **ICF/IID: A facility licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities** serving the under 21 year old population has the following additional covered services:
  - All screening, evaluation and treatment services that are covered under Medicaid EPSDT provisions
  - Bed hold days = 52/year
  - Dental services = screening only in rate; treatment is paid by Medicaid directly
  - Custom wheelchairs; gait trainers
  - For children with IVs: IV pumps

Pharmacy

- **Keep pharmacy as is**. MCOs should pay for any physician-ordered medications: FDA Approved Legend and Non-legend drugs approved and ordered without prior authorizations. See note below in Prior Authorization about CMS Federal guidelines.

- **No p/a delays can be allowed**; prior authorization requests should be responded to within 24 hour.
    - The regulation at 42 CFR 483.60 (F425) requires that the facility provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident.
- Assure smooth transition of medications through MCOs, service levels, etc.
- Request a 15 day supply for coverage between gaps/lapse in coverage.
- MCOs should have a consistent pharmacy formulary. Prior authorization required only for off formulary medications and only applicable for Medicaid only residents.

Transportation

- Keep system, as revised in late 2015, recognizing that providers request transportation when medically necessary only.
    - When providers provide transportation, look at CTS requirements to remove burdensome and costly administrative requirements. Provider exemptions?
- Any new MCO's be required to work with CTS; consistent practice makes the system more effective and efficient for operations, billing, residents can expect same level of service no matter who the provider.
- In cases where an approved provider is not available in the member area, the MCO will pay for the services of an alternate provider.

Prior Authorization

- Applicable for Medicaid only. Not needed for services covered by Medicare or the primary insurance. (Prior authorizations are the responsibility of the service provider)
- **Definition: Pre-Authorization is a decision by a health plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary*.**
- Providers must operate first under CMS Federal guidelines. Centers for Medicare & Medicaid guidelines: 42 CFR – Requirements for participation (for NF). Providers are required to follow best practice and document reasoning behind practice. Providers are required by these rules to manage and coordinate the care to allow for the highest practicable level of function.
- There should be no pre-authorization requirements for CMS required tasks including but not limited to:
    - Certifications, recertification §483.30(c) Frequency of physician visits:
      (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.
- Any p/a requirement by an MCO must take into account the volume of requirements already in place. Prior authorizations should not be allowed to slow down or interfere with prompt implementation of services, treatments, medications or equipment as required by CMS.
- MCO's should be required to follow the same best practices guidelines as practitioners are required by these rules.
- Nursing facilities are held harmless if another provider does not get the appropriate authorization.
- To maintain continuity, prior authorizations for services, drugs, therapies and equipment should carry over to new MCOs for a six month period, post enrollment. The MCO agrees not to terminate such pre-authorizations without advance notice and the opportunity for appeal substantial reductions in services.

Network adequacy

- MCOs must have an adequate network of providers specializing in care for nursing facilities to care for the population residing in nursing homes.
- Any willing provider.
- Choice of private, county and private non-for-profit.
- Regional areas.
- Needs to be sufficient Medicaid beds to meet need.
- All issues presented by residents or potential residents needs to be adequately addressed within the facility (i.e. behavioral issues, mental health issues).
- Determination of current unmet need required in order to know extent of network needed
- MCOs must identify and support community based “transition-out” programs to move enrollees when appropriate to community-based settings from nursing facilities and other institutions, and develop such programs where they don’t exist or exist only at a rudimentary level.
- CMS and the state must ensure that beneficiary access to providers does not decrease.
- States and MCOs must be required to establish processes to encourage providers to enroll in MCO networks.
- Because enrollment in an MCO should never require a person to move, an MCO must be required to make payment available to any appropriately certified nursing facility in which an enrollee is living at the time of enrollment, for services provided to that enrollee. The MCO must provide payment at the network rate if that rate is higher than the standard Medicaid rate.

Quality metrics and outcome measurements

- For providers select from existing publicly reported CMS quality measures.
- MCOs must utilize the most current metrics and measurements as set forth under CMS’s Nursing Home Quality Initiative.
- MCOs should report/track any service lags related to Prior Authorization processes.
- MCOs should report/track any consumer and provider complaints.
- MCOs should report payment timeliness.
- MCOs should report/track billing issues and resolutions.

Patient safety

- Provider agrees, to the best of its knowledge and ability, Covered Services shall be provided in accordance with all applicable federal and State laws.
- MCO acknowledges that State and federal regulations require reporting of internal investigations within facility. Such investigations and reporting of these incidents are not subject to reporting requirements of the MCO.
- MCO agrees that onsite inspections and investigations into members care are regulated by state and federal authorities. MCO agrees to accept information, investigation and outcome of internal investigatory process or that of regulatory authority in lieu of MCO conducting its own investigation
- States must have an oversight and monitoring plan that clarifies what role each of the relevant agencies will play. A clear lead agency ultimately responsible for the program should be identified.

- States must restructure and rehire as necessary to ensure that staff have expertise in overseeing, monitoring, and contracting with MCOs.
- The oversight and monitoring plan must include activities to monitor MCO performance over time as well as activities that can quickly identify and resolve current problems.
- States must utilize stakeholder groups and independent ombudsman in its monitoring and oversight plan.

Grievance and appeals

- In situations where disagreement arises over treatment decisions, the MCOs Medical Director and Provider's Medical Director will discuss the case to determine if a mutually agreeable solution can be reached. If such solution is reached, MCO agrees to pay for the services provided to the Covered Person.
- Beneficiaries must maintain their existing Medicaid due process rights - including the right to notice and appeal a MCO decision, including any decisions to deny, reduce or terminate benefits.
- Decision-makers in the appeal process must be trained to evaluate the necessity of nursing home care.
- Individuals enrolled in the MCO must have the right to file grievances about the service and treatment provided by the MCO, its contractors and providers.
- The state must collect, and share publicly, data on the rate of denials (including partial denials) of requested services, the number of appeals and grievances filed and the number of appeals that result in the reversal of a MCO decision.
- The state must establish an independent managed care ombudsman to assist individuals through the appeals and grievances process. (see details below).

Office of Ombudsman

- The Managed Care Ombudsman is independent from managed care plans
- Assists members in obtaining medically necessary covered services for which the managed care plan is contractually responsible for
- Provides plan member education on:
    - Concept of managed care
    - Member rights under the managed care program
    - Grievance and appeals procedures
- Provides assistance in making referrals to other advocacy agencies when appropriate
- Assists individuals with navigating the program, including (NOTE: some of these may be already covered by the Office of the Long-Term Care Ombudsman):
    - Understanding benefits, coverage or access rules and procedures, and participant rights and responsibilities;
    - Making enrollment decisions;
    - Exercising rights and responsibilities, including Olmstead rights around community integration;
    - Accessing covered benefits;
    - Resolving billing problems;
    - Appealing MCO denial, reduction or termination of service decisions;

    - Raising and resolving quality of care and quality of life issues;
    - Ensuring the right to privacy, consumer direction and decision-making; and
    - Understanding and enforcing an individual's civil rights.
- Ombudsman should be accessible to all individuals through telephonic helplines, and where appropriate, in-person appointments.
- MCOs must be required to notify individuals of availability of the ombudsman in enrollment and other marketing materials including annual notices summarizing grievance and appeal procedures, and all notices of denial, reduction or termination of a service, whether sent in writing or in another alternative format.
- The ombudsman must be permitted to participate in in participant advisory committee meetings with MCOs and state officials. The ombudsman should prepare reports to the state, at least annually. The reports should be made public.
- The ombudsman must have established channels of access to senior officials at the MCO and the state. Periodic meetings should take place between the ombudsman and MCOs and the ombudsman and the state to discuss patterns and systemic issues.
- The ombudsman must have expertise in the on-the-ground delivery of long-term care supports and services.

Rates and Payments

- The determination of nursing facility rates should remain with DHHS. This would allow for recognized costs as validated by the Medicaid Cost Reports and provide consideration for differences in resident acuity and capital costs. Consider annual determination of the Medicaid Payment Rate.
- Access to services is impacted by fair and equitable nursing facility services.
- The basic rate structure should be at least equal to the combined Medicaid Payment Rate and MQIP. Proshare needs to be factored into rates for County nursing facilities.
- **Atypical rates** should be developed for specialized units/facilities (including Cedarcrest and Crotched Mountain). Atypical rates currently in place should be honored for 18 months. Atypical rates should be developed for residents with behavioral issues.
- **Ventilator Atypical services:** Direct billed to Medicaid/MCO
    - Rental of vent with stand
    - Vent humidification
    - Sterile water for humidification
    - Vent tubing
    - In-line suction catheters
    - Custom trachs
- There should be an add-on rate schedule for therapy services (with prior authorization).
- Clean bills should be paid within 15 days.
- Nursing facilities should bill MCOs within 90 days of service.
- For purposes of this Agreement, a Clean Claim means a claim which contains all of the [UB-92] or [HCFA 1500] (or successor standard) data elements, and is submitted within the timeframes set forth herein.
- The MCO will pay interest at the rate of 15% per annum on clean claims paid after 45 days of receipt.

- “Take-back” will occur within one year after the claim has been adjudicated by the MCO).
- Prior to initiating any single recoupment from a NF/ALF, the MCO should be required to provide a detailed letter to the NF/ALF describing the basis for the recoupment, the process to be utilized to recoup the funds, the total recoupment amount, total number of claims, range of dates for the claims being recouped, and describing the NF’s/ALF’s appeal rights. An electronic file that shows the patient ID, dates of service, original claim numbers, dates of payment, amounts paid, and amounts recouped should be generated and provided by the MCO.
- Billing systems for the MCOs should be as well aligned as possible to reduce administrative burden.
- MCO overhead cost must not come out of the provider funding pool.